STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150024	A. BUILDING _____ B. WING _____	01/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLIAM N WISHARD MEMORIAL HOSPITAL	1001 W 10TH ST INDIANAPOLIS, IN 46202

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for the investigation of 1 (one) State hospital complaint investigation. Complaint: #IN00094342 Unsubstantiated; lack of sufficient evidence. Facility: #005023 Date: 1-31-2012 Surveyor: Karilyn M. Tretter, RN Public Health Nurse Surveyor William N. Wishard Memorial Hospital is in compliance with 410 IAC 15-1.6.2, Emergency services, Indiana State Hospital Licensure Rules. QA: claughlin 03/22/12	S 000		